STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPI	LETED
		155637	A. BUII B. WIN			04/20/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	ROVIDER OR SUPPLIE	₹					
CHICAC	OLAND CHRISTIAI	NIVIII ACE		1	117TH AVE N POINT, IN46307		
CHICAG	JLAND CHRISTIAI	VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0000							
			1				
			F0	000			
	Surveyor: Sande	ers, Regina					
	This visit was fo	or a Post Survey Revisit					
		certification and State					
		y completed on 02/23/11.					
	Licensure Surve	y completed on 02/23/11.					
		110 10 100 2011					
	Survey dates: Ap	pril 18, 19, and 20, 2011					
	Facility number:	001198					
	Provider number	r: 155637					
	AIM number:	100471000					
	Survey team:						
	_	DN TC					
	Regina Sanders,						
	Sheila Sizemore						
	Marcia Mital, R						
	Kelly Sizemore,	RN					
	Census bed type	:					
	SNF: 24						
	SNF/NF: 106						
	Residential: 41						
	Total: 171						
	Census payor ty	pe:					
	Medicare: 26						
	Medicaid: 80						
	Other: 65						
	Total: 171						
	10111. 1/1						
	Commiss 14						
	Sample: 14	1 0					
	Supplemental sa	mple: 2					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC12 Facility ID:

001198

If continuation sheet

TITLE

PRINTED: 05/13/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	A. BUILDING B. WING	E CONSTRUCTION 00 EET ADDRESS, CITY, STATE, Z	(X3) DATE COMPI 04/20/2	LETED		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			6685 E 117TH AVE CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	findings in accor	ies also reflect State rdance with 410 IAC 16.2. ompleted on April 25,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC12 Facility ID:

ity ID: 001198

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIHIT	NI) C	00	COMPL	ETED
		155637	A. BUILI B. WING			04/20/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			117TH AVE		
CHICVE	OLAND CHRISTIAN	JVIIIAGE			N POINT, IN46307		
СПСАВ	JEAND CHRISTIAN	VILLAGE		CROWN	N FOINT, IN40307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0225		ot employ individuals who					
SS=D	_	guilty of abusing, neglecting,					
	•	dents by a court of law; or					
		g entered into the State					
		y concerning abuse, neglect, esidents or misappropriation					
		and report any knowledge it					
		a court of law against an					
		would indicate unfitness for					
		e aide or other facility staff to					
		de registry or licensing					
	authorities.						
		ensure that all alleged					
		g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are					
		tely to the administrator of other officials in accordance					
		ough established procedures					
		tate survey and certification					
	agency).	tate carrey and commodition					
	3,7						
	The facility must h	ave evidence that all					
	alleged violations	are thoroughly investigated,					
	•	further potential abuse while					
	the investigation is	s in progress.					
		nvestigations must be					
	-	ministrator or his designated					
	•	d to other officials in State law (including to the					
		certification agency) within 5					
		e incident, and if the alleged					
		d appropriate corrective					
	action must be tak						
İ	Rased on a	bservation,	F02	25	F 225 D 1. What corrective		05/13/2011
	Dascu OII O	osci vanon,			action (s) will be accomplished		-
	record revi	ew. and			those residents found to have	-	
					been affected by the deficien		
	ınterview, 1	the facility failed			A complete skin assessment		
		•			completed, on Resident #76	tO	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155637	A. BUI B. WIN	LDING IG		04/20/2011
NAME OF	PROVIDER OR SUPPLIEI	 		STREET A	DDRESS, CITY, STATE, ZIP CODE	
				1	117TH AVE	
	OLAND CHRISTIAI			<u> </u>	N POINT, IN46307	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	to thoroughly investigate,				determine resident's skin condition and ascertain factor	ors
	injuries of	unknown origin			that might lead to additional bruising. This resident has a	1
	related to r	nultiple bruising			history of bruising therefore; identified skins issues related	
	found on 3	of 14 residents			bruise(s) of unknown origin v	ı
	reviewed f	or injuries of			thoroughly investigated by a multidisciplinary team compr of the Director of	ised
	unknown c	origin in a sample			Nursing/Designee and the	
	of 14. (Re	sident #12, #49			Resident Care Coordinator /Designee and with an	
	and #76)	,			appropriate Resident Care P	lan
					implemented. b. A complete	
					assessment was completed Resident # 12. A complete s	
	Findings in	nclude:			assessment was completed	with
					no new bruises identified. A issues of bruises /injuries of	
	1 Resider	nt #76's record			unknown origin will be thorou	
					investigated by a multidiscipl team comprised of the Direc	- 1
	was review	ved on 4/18/11 at			Nursing/Designee and the	
	11:22 a.m.	Resident #76's			Resident Care Coordinator/Designee and w	rith
	diagnoses	included, but			an appropriate Resident Car Plan implemented. c. A com	ı
	were not li	mited to history			skin assessment was comple on Resident # 49. A comple	eted
	of falls, mu	iscle weakness,			skin assessment was comple	eted
	1	mer's disease.			with no new bruises identified issues of bruises/injuries of	d. All
		inor b diboubo.			unknown origin will be thorou	
					investigated by a multidiscipl team comprised of the Direct	· 1
	A Significa	ant Change MDS			Nursing/Designee and the	
	(Minimum	Data Set)			Resident Care Coordinator/Designee and w	ith
	assessment	t, dated 2/10/11,			an appropriate Resident Car	e
		, autoa 2/10/11,			Plan implemented. 2. How residents having the potential	
						11 10

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ		NSTRUCTION 00	(X3) DATE S COMPL	
		155637	A. BUI B. WIN	LDING IG		04/20/2	011
NAME OF I	PROVIDER OR SUPPLIE	 			ADDRESS, CITY, STATE, ZIP CODE		
	OLAND CHRISTIA			1	117TH AVE N POINT, IN46307		
		STATEMENT OF DEFICIENCIES		ID	VI OIIVI, IIV 4 0507		(VE)
(X4) ID PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	indicated F	Resident #76 had			be affected by the same defi practice will be identified and		
	short and 1	ong term			what corrective action (s) wil taken. a. New investigative		
	memory pi	oblems and was			protocol for bruises/injuries of	of	
	severely in	npaired for			unknown origin has been developed and implemented		
	1	aking. The MDS			protocol will be used to thoro investigate all bruise(s) /injur	• •	
	assessmen	t indicated the			unknown origin. A multidisciplinary team compr	ised	
	resident ha	d not transferred			of Director of Nursing/Desigr and the Resident Care	nee	
	or ambulat	ed. The MDS					
	assessmen	t indicated the			responsible to ensure that the new investigative protocol is		
	resident re	quired extensive			being implemented. Residen will be re-assessed using the	e new	
	one person	assistance for			protocol and resident care pl will be updated as needed.	3.	
	bed mobili	ty and was			What measures will be put i place or what systemic chan	ges	
	totally dep	endent for			will be made to ensure that t deficient practice does not re		
	dressing, e	ating, toilet use,			 a. New protocol/forms for reporting and investigating 		
	personal h	ygiene, and			bruises /injuries of unknown were developed. b.	origin	
	bathing.				Incident/Accident reports will placed in designated medica		
					record box on each unit. The	;	
	A Nurses'	Note, dated			incident /accident reports will collected by medical records		
	4/5/11 at 1	,			during daily Monday through Friday and nursing house		
		Bruise found R			supervisor will collect on the end. The reports will be give		
	(right) upper (arrow				the Director of Nursing/Design	gnee.	
	`	`	c. Director of Nursing /Designee will review incident report /accident report and initiate investigation. d. After review of		c. Director of Nursing /Designee will review incident report		
	pointing up	o) allii			, of		
					investigation. d. Alter review	, OI	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155637 04/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6685 E 117TH AVE CHICAGOLAND CHRISTIAN VILLAGE **CROWN POINT, IN46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE investigation by the Director of proximal/elbow, 2 1/2 cm Nursing /Designee, the corporate (centimeters) by 3 nursing consultant will be informed of findings. The Director cm...unknown origin...." of Nursing/Designee will proceed according to Indiana reportable regulations as directed if investigation indicates. e. A A Nurses' Note, dated Directed in-service training on new investigative protocol will be 4/7/11 at 6:00 a.m., provided to nursing staff. 4. How the corrective action (s) will be indicated the resident's monitored to ensure the deficient practice will not recur, i.e. what bruises to the right elbow quality assurance program will be were healing. put into place. a. Incident/Accident reports will be reviewed at the morning stand up meeting. This process will be on A Nurses' Note, dated going. b. Director of Nursing will meet with individual nurses if new 4/13/11 at 1:00 p.m., protocol /procedures are not being followed. Nurse will be indicated "Bruises c/ (with) re-educated and disciplined when appropriate. c. Director of abrasions to R elbow noted. Nursing /Designee will review Purple areas is (sic) approx. investigation documentation on incident/accident of unknown (approximate) 8.5 cm by 7 origin and log when completed. A summary of investigation(s) will cm et 1 cm x (by) 1 cm be presented monthly to the Q/A committee and this will be distally. Abrasions within ongoing. F 225 D 1. What corrective action (s) will be bruise are approx. 2 cm x accomplished for those residents found to have been affected by 0.8 cm et (and) 2.5 cm x 1.8 the deficient a. A complete skin assessment was completed, on cm. Bruise is of unknown Resident #76 to determine resident's skin condition and origin...." ascertain factors that might lead to additional bruising. This

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUII	A. BUILDING 00		COMPLETED	
		155637	B. WIN			04/20/2011	
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	resident has a history of brui	DATE	
					therefore; identified skins iss		
A Witness Statement Form,					related to bruise(s) of unkno	wn	
		· ·			origin will be thoroughly investigated by a multidiscip	linany	
		1 at 1:00 a.m.,			team comprised of the Direc	-	
	indicated "	Bruises found on			Nursing/Designee and the		
	resident's a	rm while doing			Resident Care Coordinator /Designee and with an		
		•			appropriate Resident Care F	Plan	
	PICC (peri	pherally inserted			implemented. b. A complete	skin	
	central cath	neter) line			assessment was completed Resident # 12. A complete s		
		<i>'</i>			assessment was completed		
	dressing ch	O			no new bruises identified. A		
	forearm pu	rple bruises			issues of bruises /injuries of unknown origin will be thorou		
	noted 3 cm	wide 2 1/2 from			investigated by a multidiscip		
					team comprised of the Direc	tor of	
	unknown o	riginPossibly			Nursing/Designee and the Resident Care		
	with ADL ((activities of			Coordinator/Designee and w		
	daily living	r)"			an appropriate Resident Car Plan implemented. c. A com		
))			skin assessment was comple		
					on Resident # 49. A comple		
	An Accide	nt/Incident			skin assessment was comple with no new bruises identifie		
	Report, dat	ed 4/13/11,			issues of bruises/injuries of unknown origin will be thorou		
	provided by	y the Nurse			investigated by a multidiscip	linary	
	Consultant	on 4/18/11 at			team comprised of the Direc Nursing/Designee and the	tor of	
	1:07 p.m., i	indicated			Resident Care	,ith	
	•				Coordinator/Designee and w an appropriate Resident Car	I	
	''When 1r	specting another			Plan implemented. 2. How	other	
	bruise I not	ticed a new			residents having the potentia		
	bruise of unknown				be affected by the same defi practice will be identified and		
	Diuise di ui	IIKIIUWII			what corrective action (s) wil	l be	
					taken. a. New investigative		

l ·		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155637	B. WIN			04/20/2	011
NAME OF	PROVIDER OR SUPPLIEI	2		1	ADDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAI	N VII I AGE		1	117TH AVE N POINT, IN46307		
				L	N FOINT, IN40307		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	origin"	There was a lack			protocol for bruises/injuries of unknown origin has been	of	
	of docume	ntation of an			developed and implemented protocol will be used to thoro		
	investigation	on of why the			investigate all bruise(s) /injurunknown origin. A	•	
	bruises occ	curred. There			multidisciplinary team compr	rised	
	was a lack				of Director of Nursing/Desigr and the Resident Care	nee	
		tion of a Witness			Coordinator/Designee will be responsible to ensure that the		
	Statement	Form			new investigative protocol is		
	Statement	l'Olli.			being implemented. Residen will be re-assessed using the		
					protocol and resident care pl		
	During an	interview on			will be updated as needed.	3.	
					What measures will be put i place or what systemic chan		
		1:55 p.m., the			will be made to ensure that t	•	
	ADoN (As	sistant Director			deficient practice does not re	ecur	
	of Nursing) indicated she			a. New protocol/forms for reporting and investigating		
	was not su	re how the			bruises /injuries of unknown were developed. b.	origin	
	bruises occ	ourred			Incident/Accident reports will		
	oranses occ	Juiica.			placed in designated medica record box on each unit. The		
					incident /accident reports wil		
	During an	interview on			collected by medical records during daily Monday through		
	4/19/11 at	12:55 p.m., the			Friday and nursing house supervisor will collect on the		
	DoN (Dire	ctor of Nursing)			end. The reports will be give	n to	
	indicated t	he investigation			the Director of Nursing/Desig	-	
	for the bru	ises found on			will review incident report /accident report and initiate		
	4/5/11 and /4/13/11, had been initiated on 4/18/11.				investigation. d. After review investigation by the Director		
					Nursing /Designee, the corpo		
					nursing consultant will be informed of findings. The Dir	ector	
					anomica of infamigo. The bit	00101	

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPL	
	-	155637	A. BUII B. WIN			04/20/2	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER		6685 E 117TH AVE				
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROWN	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	2. Resident #12 initial tour on 4/1 RN #3 present, in hallway on the B purple bruises not elbow. RN #3 in the resident had to indicated the resident.	was observed during the 18/11 at 10:08 a.m., with her wheelchair in the hall. There were 3 oted on the resident's left adicated she did not know the bruises. She ident was confused.			of Nursing/Designee will pro- according to Indiana reportal regulations as directed if investigation indicates. e. A Directed in-service training of new investigative protocol wi provided to nursing staff. 4. the corrective action (s) will be monitored to ensure the defi- practice will not recur, i.e. wh quality assurance program wi put into place. a. Incident/Accident reports will reviewed at the morning star meeting. This process will be going. b. Director of Nursing meet with individual nurses i protocol /procedures are not being followed. Nurse will be re-educated and disciplined appropriate. c. Director of Nursing /Designee will review investigation documentation incident/accident of unknown origin and log when complete summary of investigation(s) be presented monthly to the committee and this will be ongoing.	ceed ble an ill be How be cient hat vill be l be nd up e on g will f new when h ed. A will	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155637	B. WIN	G		04/20/2	011
NAME OF E	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOLI EIEK			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ecord was reviewed on					
	_	.m. Resident #12's					
	diagnoses includ	ed, but were not limited					
	to, osteoporosis,	dementia, and					
	hypertension.						
	The nurses! notes	s, last documentation was					
	3/26/11, there was						
	· ·						
	documentation o	T the bruises.					
	An annual MDS	assessment, dated					
		d the resident's cognitive					
	· ·	nely impaired and the					
		limited to extensive					
		staff member for bed					
		rs, ambulation, dressing,					
	personal hygiene	-					
	personal hygiene	, and batimig.					
	Resident #12's re	ecord was reviewed on					
	4/19/11 at 9:20 a	.m. There was a lack of					
	documentation in	n the resident's nurses'					
	notes related to the	he bruises observed on					
		1 4/18/11 at 10:08 a.m.					
	During an intervi	iew on 4/19/11 at 9:25					
	a.m., RN #3 indi						
	l '	ot about them" (the					
	, , , ,	licated she should have					
	l '	uises and began an					
	investigation.						
	mivestigation.						
	 During an intervi	iew on 4/19/11 at 9:50					
	1	cated she had measured					
	a.111., KIN #3 11101	catcu she hau measureu					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ì		INSTRUCTION 00	(X3) DATE S COMPL	
		155637	B. WIN	LDING G		04/20/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307		
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IAG		indicated the resident	+	IAU			DATE
		her left arm and 1 bruise					
		The bruises on her left					
	_	which were purple in					
	· ·	1. 4 cm by 1.9 cm, 4.5 cm					
		.8 cm by 1.2 cm. The					
	l -	was on the resident's					
	•	ole in color and measured					
		a. She indicated she was					
	beginning the inv	estigation for the					
	bruises.						
		r of the C-Hall on					
		a.m. through 10:40					
	1	eted with the Restorative					
		ne tour, the Restorative					
		Resident #49 was not					
		d required one person to					
		ansfers. Resident #49's					
	call light was act						
		e answered the Resident's					
	~	ident requested to use the					
		Restorative Nurse then					
		esident onto the toilet.					
	_	Fer, with the Restorative					
		e two small purple					
		on the Resident's left					
	· ·	ing an interview at the vation, Resident #49					
		not know how she got					
		ing an interview after the					
		d been completed, the					
		e indicated she had been					
	unaware of the b						
	Land Traine of the O						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) N			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155637	B. WIN			04/20/2	011
		I	D. WII.		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	8			117TH AVE		
CHICAG	OLAND CHRISTIAN	N VILLAGE		I	N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	Resident #49's re 04/19/11 at 6:45 diagnoses includ to, dementia and The Resident's S Minimum Data S 03/08/11, indicate cognitive status with a score of 9 required extensive person for transform The, "Social Ser and Plan", dated resident had show problems. There were no North Resident's record indicate the resident inner thigh. During an interval. During an interval. The Restoral had informed the the bruises on the thigh. The Restoral investigation of the done and they we investigation to discovered the state of the s	ecord was reviewed on a.m. The Resident's led, but were not limited Parkinson's Disease. ignificant Change Set Assessment, dated ted the resident's was moderately impaired and the resident we assistance of one ferring and toileting. vice Update Assessment 03/08/11, indicated the rt and long term memory furses' Notes in the dafter 03/15/11 to dent had bruising on the iew on 04/19/11 at 7:15 ative Nurse indicated she are Nurse on 04/18/11 about the Resident's left inner orative Nurse indicated and the bruising had not been ould start the		TAG	DEPICIENCY)		DATE
		<u>G</u> ,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155637	A. BUILDING B. WING		04/20/2011
NAME OF I	PROVIDER OR SUPPLIER		I	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE	
CHICAG	OLAND CHRISTIAN	I VILLAGE		N POINT, IN46307	
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TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
		a.m., indicated the e bruises, two on the			
		nd one below the left			
	· ·	sured, 2 cm (centimeters)			
	by 1.5 cm, 1.5 cm 0.5 cm.	m by 1.5 cm, and 1 cm by			
	V.5 VIII.				
		d on 02/23/11. The			
	*	implement a systemic nto prevent recurrence.			
	pium or correction				
	3.1-28(d)				
F0226 SS=D	written policies and mistreatment, neg	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property.			
	Based on observa	ation, record review and	F0226		05/13/2011
	· ·	cility failed to follow the or investigating unusual		F 226 D 1. What corrective act	ion
	occurrences relat			(s) will be accomplished	for

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155637 04/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6685 E 117TH AVE CHICAGOLAND CHRISTIAN VILLAGE **CROWN POINT, IN46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE those residents found to unknown origin for 3 of 14 residents have been affected by the reviewed for injuries of unknown origin deficient in a sample of 14 residents. (Resident #12, #49, and #76) A complete skin assessment was completed, on Resident Findings include: #76 to determine resident's skin condition and ascertain 1. Resident #76's record was reviewed on 4/18/11 at 11:22 a.m. Resident #76's diagnoses included, factors that might lead to but were not limited to history of falls, muscle additional bruising. This weakness, and Alzheimer's disease. resident has a history of bruising therefore: identified A Significant Change MDS (Minimum Data Set) skins issues related to assessment, dated 2/10/11, indicated Resident #76 bruise(s) of unknown origin had short and long term memory problems and was severely impaired for decision making. The will be thoroughly MDS assessment indicated the resident had not investigated by a transferred or ambulated. The MDS assessment multidisciplinary team indicated the resident required extensive one comprised of the Director of person assistance for bed mobility and was totally Nursing/Designee and the dependent for dressing, eating, toilet use, personal Resident Care Coordinator hygiene, and bathing. /Designee and with an A Nurses' Note, dated 4/5/11 at 1:00 a.m., appropriate Resident Care indicated "Bruise found R (right) upper (arrow Plan implemented. pointing up) arm proximal/elbow, 2 1/2 cm (centimeters) by 3 cm...unknown origin...." A complete skin A Nurses' Note, dated 4/7/11 at 6:00 a.m., assessment was completed indicated the resident's bruises to the right elbow on Resident #12. A were healing. complete skin assessment was completed with no new A Nurses' Note, dated 4/13/11 at 1:00 p.m., bruises identified. All indicated "Bruises c/ (with) abrasions to R elbow issues of bruises /injuries of noted. Purple areas is (sic) approx. (approximate) 8.5 cm by 7 cm et 1 cm x (by) 1 cm distally. unknown origin will be Abrasions within bruise are approx. 2 cm x 0.8 cm thoroughly investigated by a et (and) 2.5 cm x 1.8 cm. Bruise is of unknown multidisciplinary team origin...." comprised of the Director of

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637 A. BUILDING D0 O4/20/2011 NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307	
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A Witness Statement Form, dated 4/5/11 at 1:00 p.m., indicated "Bruises found on resident's arm while doing PICC (peripherally inserted central catheter) line dressing changes. R forearm purple bruises noted 3 cm wide 2 1/2 from unknown originPossibly with ADL (activities of daily living)" An Accident/Incident Report, dated 4/13/11, provided by the Nurse Consultant on 4/18/11 at 1:07 a.m., indicated "When inspecting another bruise I noticed a new bruise of unknown origin" There was a lack of documentation of an investigation of why the bruises occurred. There was a lack of documentation of a Witness Statement Form. During an interview on 4/18/11 at 1:55 p.m., the ADoN (Assistant Director of Nursing) indicated she was not sure how the bruises occurred. During an interview on 4/19/11 at 12:55 p.m., the DoN (Director of Nursing) indicated the investigation for the bruises found on 4/5/11 and /4/13/11, had been initiated on 4/18/11.	
2. How other residents having the potential to be	
affected by the same deficient practice will be	
identified and what	
corrective action (s) will be	
taken	
a. New investigative	
protocol for bruises/injuries	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 04/20/2011	
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IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	of unknown origin has developed and implemented this pro will be used to thoroug investigate all bruise(s /injuries of unknown or A multidisciplinary tear comprised of Director Nursing/Designee and Resident Care Coordinator/Designee be responsible to ensuthat the new investigate protocol is being implemented. Resident be re-assessed using new protocol and resident care plan will be update needed. 3. What measures we put into place or what systemic changes will made to ensure that the deficient practice does recure. a. New protocol/form reporting and investigate bruises /injuries of unk origin were developed b. Incident/Accident reports will be placed it designated medical rebox on each unit. The incident /accident reports incident reports inc	been stocol ghly s) rigin. m of I the will ure tive ots will the dent ted as will be be ne s not ons for ating known . in cord	
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				will be collected by me records during daily Monday through Friday nursing house supervise will collect on the week The reports will be given the Director of Nursing/Designee. c. Director of Nursing /Designee will review incident report /accider report and initiate investigation. d. After review of investigation by the Director of Nursing /Designee, for corporate nursing consultant will be inform of findings. The Director Nursing/Designee will proceed according to Indiana reportable regulations as directed investigation indicates. e. A Directed in-servitarining on new investigative protocol with provided to nursing start of the deficient practice will not recur, for the work of the corrective action (s) will be monited to ensure the deficient practice will not recur, for the work of the corrective action (s) will not recur, for the correction action (s) will not recur, for the cor	y and sor a end. en to den to	
				what quality assurance	;	

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IAU	REGULATORY OR	Loc IDENTIFTING INFORMATION)	IAG	program will be put interplace. a. Incident/Accident reports will be reviewed the morning stand up meeting. This process be on going. b. Director of Nursing meet with individual nurif new protocol /proced are not being followed Nurse will be re-educated and disciplined when appropriate. c. Director of Nursing /Designee will review investigation document on incident/accident of unknown origin and lowhen completed. A summary of investigation will be presented mornithe Q/A committee and will be ongoing.	ed at will g will urses dures ated ag atation f g ion(s) thly to d this
				1. What corrective a (s) will be accomplished.	

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				those residents found to	 o	
				have been affected by t	the	
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				a. A complete skin		
				assessment was		
				completed, on Residen		
				#76 to determine reside skin condition and asce		
				factors that might lead to		
				additional bruising. Thi		
				resident has a history o		
				bruising therefore; iden		
				skins issues related to		
				bruise(s) of unknown or	rigin	
				will be thoroughly		
				investigated by a		
				multidisciplinary team	_	
				comprised of the Direct		
				Nursing/Designee and the Resident Care Coordinates		
				/Designee and with an	alUi	
				appropriate Resident C	are	
				Plan implemented.	G. O	
				- I		
				b. A complete skin		
				assessment was compl	eted	
				on Resident # 12. A		
				complete skin assessm		
				was completed with no	new	
				bruises identified. All	oo of	
				issues of bruises /injurious unknown origin will be	28 OI	
				thoroughly investigated	hv a	
				multidisciplinary team	Jya	
				comprised of the Direct	or of	

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				Nursing/Designee and Resident Care Coordinator/Designee with an appropriate Resident Care Plan implemented. c. A complete skin assessment was compon Resident # 49. A complete skin assessment was completed with no bruises identified. All issues of bruises/injurie unknown origin will be thoroughly investigated multidisciplinary team comprised of the Direct Nursing/Designee and Resident Care Coordinator/Designee with an appropriate Resident Care Plan implemented. 2. How other resident having the potential to affected by the same	and pleted nent new es of d by a tor of the and
				deficient practice will be identified and what corrective action (s) witaken a. New investigative	II be
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					of unknown origin has b	een	
					developed and		
					implemented this proto	ocol	
					will be used to thorough	ılv	
					investigate all bruise(s)		
			1		/injuries of unknown orig	nin	
					A multidisciplinary team	-	
					comprised of Director of		
					Nursing/Designee and t		
					Resident Care	116	
						.:11	
					Coordinator/Designee v		
					be responsible to ensur		
					that the new investigative	/e	
					protocol is being		
					implemented. Residents	s will	
					be re-assessed using th	ne	
					new protocol and reside	ent	
					care plan will be update		
					needed.		
					1100000.		
					3. What measures wi	ll he	
					put into place or what	50	
					•		
					systemic changes will b		
					made to ensure that the		
					deficient practice does i	not	
			1		recur		
			1		 a. New protocol/forms 		
					reporting and investigat	ing	
					bruises /injuries of unkn	own	
					origin were developed.		
					b. Incident/Accident		
			1		reports will be placed in		
					designated medical rec		
			1		box on each unit. The	514	
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					incident /accident repor	īS	

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				action (s) will be mon to ensure the deficier practice will not recur what quality assurand	it , i.e.	

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NAME OF I	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	117TH AVE		
CHICAG	OLAND CHRISTIAN	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
					program will be put into		
					place.		
					 a. Incident/Accident 		
					reports will be reviewed	at	
					the morning stand up		
					meeting. This process v	vill	
					be on going.		
					b. Director of Nursing	will	
					meet with individual nur		
					if new protocol /procedu		
					are not being followed.	1100	
					Nurse will be re-educate	ad	
						eu	
					and disciplined when		
					appropriate.		
					c. Director of Nursing		
					/Designee will review		
					investigation documenta	ation	
					on incident/accident of		
					unknown origin and log		
					when completed. A		
					summary of investigatio	n(s)	
					will be presented month		
					•	•	
					the Q/A committee and	เบเร	
					will be ongoing.		
					F 226 D		
					What corrective act	ion	
					(s) will be accomplished	1 101	

PRINTED: 05/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		(X2) M A. BUII B. WIN	LDING	00	(X3) DATE : COMPL 04/20/2	ETED	
	ROVIDER OR SUPPLIER			6685 E 1	DDRESS, CITY, STATE, ZIP CODE 117TH AVE I POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					those residents found to have been affected by the deficient a. A complete skin assessment was completed, on Resident #76 to determine reside skin condition and ascefactors that might lead the additional bruising. This resident has a history of bruising therefore; ident skins issues related to bruise(s) of unknown or will be thoroughly investigated by a multidisciplinary team comprised of the Director Nursing/Designee and the Resident Care Coordinates/Designee and with an appropriate Resident Care Plan implemented. b. A complete skin assessment was completed with no bruises identified. All issues of bruises /injuried unknown origin will be thoroughly investigated multidisciplinary team comprised of the Director comprised comprised comprised of the Director comprised compri	he int's rtain o s f ified igin or of he ator are eted ent new es of by a	

PRINTED: 05/13/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 04/20/2011
	ROVIDER OR SUPPLIER		STREET A 6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
				Nursing/Designee and Resident Care Coordinator/Designee with an appropriate Resident Care Plan implemented. c. A complete skin assessment was compon Resident # 49. A complete skin assessment was compon Resident # 49. A complete skin assessment was completed with not bruises identified. All issues of bruises/injuriunknown origin will be thoroughly investigate multidisciplinary team comprised of the Direct Nursing/Designee and Resident Care Coordinator/Designee with an appropriate Resident Care Plan implemented.	and bleted ment o new les of d by a ctor of the and
				How other resider having the potential to affected by the same deficient practice will be	be
				identified and what corrective action (s) w taken a. New investigative protocol for bruises/inj	

PRINTED: 05/13/2011 FORM APPROVED OMB NO. 0938-0391

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	A. BUI	LDING	00	COMPLETED 04/20/2011
		100001	B. WIN		PPPPG GWW GW == == ==	0-1/20/2011
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
CHICAGO	DLAND CHRISTIAN	I VILLAGE		1	117TH AVE N POINT, IN46307	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG		DATE
					of unknown origin has b	peen
					developed and	2001
					implemented this proto will be used to thorough	
					investigate all bruise(s)	· I
					/injuries of unknown orig	
					A multidisciplinary team	~
					comprised of Director of	
					Nursing/Designee and t	
					Resident Care	
					Coordinator/Designee v	vill
					be responsible to ensur	l l
					that the new investigative	ve
					protocol is being	
					implemented. Residents	
					be re-assessed using the	
					new protocol and reside	
					care plan will be update	ed as
					needed.	
					3. What measures wi	ill be
					put into place or what	
					systemic changes will b	l l
					made to ensure that the	
					deficient practice does	not
					recur	
					a. New protocol/forms	
					reporting and investigat	- I
					bruises /injuries of unkn origin were developed.	IOWII
					b. Incident/Accident	
					reports will be placed in	
					designated medical rec	
					box on each unit. The	
					incident /accident repor	ts

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	A. BUII	LDING	00 	COMPLETED 04/20/2011
		100007	B. WIN		DDDECC CITY CTATE ZID CODE	0-7/20/2011
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE	
	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	will be collected by med records during daily Monday through Friday nursing house supervise will collect on the week. The reports will be given the Director of Nursing/Designee. c. Director of Nursing /Designee will review incident report /accident report and initiate investigation. d. After review of investigation by the Director of Nursing /Designee, the corporate nursing consultant will be inform of findings. The Director Nursing/Designee will proceed according to Indiana reportable regulations as directed investigation indicates. e. A Directed in-service training on new investigative protocol we provided to nursing staff. 4. How the corrective action (s) will be monito.	and or end. In to the ector ne med or of the ector ne fill be f.
					to ensure the deficient practice will not recur, i. what quality assurance	
					what quality assurance	

	OF CORRECTION	IDENTIFICATION NUMBER: 155637	A. BUILDING	00	COMPI 04/20/2	LETED
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	N VILLAGE	CROW	N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
		#12 was observed		program will be put interplace. a. Incident/Accident reports will be reviewed the morning stand up meeting. This process be on going. b. Director of Nursin meet with individual nurse with individual nurse more protocol /proced are not being followed Nurse will be re-educated and disciplined when appropriate. c. Director of Nursin /Designee will review investigation documer on incident/accident of unknown origin and lowhen completed. A summary of investigate will be presented mone the Q/A committee and will be ongoing.	will g will urses dures ted g attation f g ion(s) thly to	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A 155637				INSTRUCTION 00	(X3) DATE S COMPL		
		A. BUI B. WIN	LDING IG		04/20/2		
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	117TH AVE N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	\neg	ID			(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		0:08 a.m., with RN					
	•	n her wheelchair in					
	_	on the B hall.					
		3 purple bruises					
		resident's left					
		#3 indicated she					
		v the resident had					
		She indicated the					
	resident was						
	Resident #12	2 was not aware of					
	how she had	gotten the bruises.					
	Resident #12	2's record was					
	reviewed on	4/18/11 at 1:05					
	p.m. Reside	nt #12's diagnoses					
	included, but	t were not limited					
	to, osteoporo	osis, dementia, and					
	hypertension	1.					
	The nurses'	notes, last					
	documentati	on was 3/26/11,					
	there was a l	ack of					
	documentati	on of the bruises.					
	An annual M	IDS assessment,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP 04/20/2	LETED	
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP COD 117TH AVE N POINT, IN46307	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	dated 3/24/1	1, indicated the				
	resident's co	gnitive status was				
	extremely in	npaired and the				
	resident requ	aired limited to				
	extensive as	sistance of one				
	staff membe	r for bed mobility,				
	transfers, an	nbulation, dressing,				
	personal hyg	giene, and bathing.				
	reviewed on a.m. There documentatinurses' notes bruises obsetour on 4/18 During an in at 9:25 a.m., she had "corabout them" indicated she	2's record was 4/19/11 at 9:20 was a lack of on in the resident's s related to the rved on the initial /11 at 10:08 a.m. atterview on 4/19/11 RN #3 indicated inpletely forgot (the bruises). She is should have bruises and began tion.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		A. BUII	LDING	NSTRUCTION 00	(X3) DATE SU COMPLET 04/20/20	ΓED	
	OVIDER OR SUPPLIER AND CHRISTIAN	VILLAGE	B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	l	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
]	During an in	terview on 4/19/11					
;	at 9:50 a.m.,	RN #3 indicated					
	she had meas	sured the bruises.					
;	She indicated	d the resident had 3					
1	bruises on he	er left arm and 1					
1	bruise on her	right arm. The					
1	bruises on he	er left arm by the					
	elbow, which	n were purple in					
	color, measu	red 1. 4 cm by 1.9					
(cm, 4.5 cm b	y 4.7 cm, and 1.8					
(cm by 1.2 cn	n. The right arm					
	•	n the resident's					
1	forearm was	purple in color					
		d 1.6 cm by 1.6					
		icated she was					
1	beginning the	e investigation for					
1	the bruises.	C					
	04/18/11 at 10:30 a.m., was comple Nurse. During the Nurse indicated Finterviewable and assist her with tracall light was actionally assist Nurse Restorative Nurse	e answered the Resident's					
	•	dent requested to use the estorative Nurse then					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/20/2	ETED
NAME OF 1	PROVIDER OR SUPPLIER	!	<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE	!	
CHICAG	OLAND CHRISTIAI	N VILLAGE			117TH AVE N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION) Lesident onto the toilet.		TAG	DEFICIENCY)		DATE
		fer, with the Restorative					
	1 -	e two small purple					
	bruises observed	on the Resident's left					
	1	ring an interview at the					
		rvation, Resident #49					
		I not know how she got					
	1	ing an interview after the					
Resident care had been completed, the Restorative Nurse indicated she had been							
	unaware of the b						
		ecord was reviewed on					
		a.m. The Resident's					
	1 -	led, but were not limited					
	to, dementia and	Parkinson's Disease.					
	The Resident's S	lignificant Change					
	Minimum Data S	Set Assessment, dated					
	03/08/11, indica	ted the resident's					
	_	was moderately impaired					
		, and the resident					
	1 ^	ve assistance of one					
	person for transf	erring and toileting.					
	The, "Social Ser	vice Update Assessment					
	and Plan", dated	03/08/11, indicated the					
	resident had sho	rt and long term memory					
	problems.						
	There was no Nu	ırses' Notes in the					
		d after 03/15/11 to					
		lent had bruising on the					
	left inner thigh.						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			Ì		NSTRUCTION 00	(X3) DATE : COMPL	
		155637	A. BUI B. WIN	LDING IG		04/20/2	
NAME OF I	PROVIDER OR SUPPLIER		D. WIL		ADDRESS, CITY, STATE, ZIP CODE		
					117TH AVE		
	OLAND CHRISTIAN			<u> </u>	N POINT, IN46307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	~	iew on 04/19/11 at 7:15					
	l '	tive Nurse indicated she					
		Nurse on 04/18/11 about					
		e Resident's left inner brative Nurse indicated an					
	~	he bruising had not been					
	done and they wo	C					
	investigation tod						
	The investigation	of the bruising, dated					
	04/19/11 at 8:15	a.m., indicated the					
		e bruises, two on the					
	~	nd one below the left					
	l '	sured, 2 cm (centimeters)					
	*	n by 1.5 cm, and 1 cm by					
	0.5 cm.						
	A facility policy,	titled "Accidents and					
	· ·	2/10, and received as					
		DoN indicated "all					
	accidents or incid						
		ses or abrasions will be					
		restigation will be					
		ermine possible causes. A					
	I -	ses/trends concerns will					
	be recorded"						
	A facility policy.	titled, "Resident Abuse					
	" " "	10, received from the					
		ing as current, indicated,					
	"1. Injuries of u	ınknown origin will be					
	investigated. An	5 5					
	classified as an 'i	njury of unknown source'					

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP - 04/20/	LETED
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CO 117TH AVE N POINT, IN46307	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	met: The source observed by any the injury could resident; and The because of the explocation of the inlocated in an area to trauma) or the observed at one por the incidence This tag was cite facility failed to	Illowing conditions are of the injury was not person or the source of not be explained by the enjury is suspicious attent of the injury or the ajury (e.g., the injury is a not generally vulnerable number of injuries particular point in time of injuries over time" In don 02/23/11. The implement a systemic in to prevent recurrence.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2011
	OVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG F0272	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) onduct initially and	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
SS=D	periodically a comp standardized repro- each resident's fur. A facility must make assessment of a re- RAI specified by the must include at lead identification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavior Psychosocial well- Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia Documentation of regarding the addiperformed through protocols; and	prehensive, accurate, oducible assessment of national capacity. The accomprehensive desident's needs, using the needs of the State. The assessment dest the following: demographic information; The patterns; The patterns; The patterns; The accomprehensive demographic information; The patterns; T			
	Based on ob	servation, record interview, the	F0272	F 272 D 1. What corrective action (a) will be accomplished	·
	facility failed to assess residents with bruises and a resident with a head injury for 3 of 14 resident's reviewed for assessments in a total sample of			(s) will be accomplished those residents found to have been affected by the deficient a. A complete skin assessment was complete on Resident # 12. A	ne

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
AND PLAIN	OF CORRECTION	155637		LDING		04/20/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	VILLAGE		1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	
1110		(Residents #12,		1710	complete skin assessme	-	
	#20, and #49	•			was completed with no i		
	$\frac{\pi 20}{1}$	')			bruises identified. All ne		
					issues of bruises /injurie	s of	
Findings include:				unknown origin will be thoroughly investigated	by a		
					multidisciplinary team	~,	
	1. Resident #	#12 was observed			comprised of the Directo	or of	
	during the in	nitial tour on			Nursing/Designee and t	he	
					Resident Care		
4/18/11 at 10:08 a.m., with RN #3 present, in her wheelchair in				Coordinator/Designee a	nd		
				with an appropriate Resident Care Plan			
	the hallway	on the B hall.			implemented.		
	There were 3	3 purple bruises					
		resident's left			b. Resident #20 susta	ined	
		#12 indicated she			laceration of right eye or		
					3/25/11 and went to the		
		v the resident had			for further evaluation an returned within a short	a	
	the bruises.				period of time .The resid	lent	
					was assessed on the sh		
	Resident #12	2's record was			after his arrival. He had	a	
	reviewed on	4/18/11 at 1:05			laceration to right eye		
					requiring sutures which	_	
	•	nt #12's diagnoses			were removed on 3/30/1	l1.	
	· ·	t were not limited					
	to, osteoporo	osis, dementia, and			c. A complete skin		
	hypertension	1.			assessment was comple	eted	
					on Resident # 49. A		
	The nurses' 1	notes last			complete skin assessme	l l	
					was completed with no		
	aocumentati	on was 3/26/11,			bruises identified. All ne		
					issues of bruises/injuries	S ()	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155637	- 1	LDING	00	04/20/2011
		10001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/20/20 11
NAME OF I	PROVIDER OR SUPPLIER			1	117TH AVE	
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
1/10	there was a l	·		ind	unknown origin will be	DATE
documentation of an					thoroughly investigated	by a
				multidisciplinary team		
	assessment t	for the bruises.			comprised of the Directo	
					Nursing/Designee and t	he
	Resident #12	2's record was			Resident Care Coordinator/Designee a	nd
	reviewed on	4/19/11 at 9:20			with an appropriate	
					Resident Care Plan	
a.m. There was a lack of documentation in the resident's nurses' notes related to the bruises observed on the initial				implemented.		
				·		
				2. How other residents		
				having the potential to b	e	
		/11 at 10:08 a.m.			affected by the same	
	1001 011 4/ 1 8/	11 at 10.08 a.iii.			deficient practice will be identified and what	
					corrective action (s) will	he
	During an in	terview on 4/19/11			taken	
	at 9:25 a.m.,	RN #3 indicated			a. New investigative	
	ŕ	npletely forgot			protocol for bruises/inju	ries
					of unknown origin has b	een
		(the bruises). She			developed and	
	indicated she	e should have			implemented this proto	l l
	measured the	e bruises.			will be used to thorough	ly
					investigate all bruise(s) /injuries of unknown orio	nin
	2 Resident +	#20's record was			A multidisciplinary team	·
					comprised of Director of	
	reviewed on	4/19/11 at 11:20			Nursing/Designee and t	
	a.m. Reside	nt #20's diagnoses			Resident Care	
	included, but	t were not limited			Coordinator/Designee w	
	·	mood disorder,			be responsible to ensure	
					that the new investigativ	′e
	i dementia, an	d depression.			protocol is being	النبيد
					implemented. Residents	o vviii

NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A nurses' note, dated 3/25/11 at 2:30 p.m., indicated "Res (resident) was found on the floor of his roomhe had suffered a laceration above the A surpose of provider of STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) DATE A nurses' note, dated 3/25/11 at 2:30 p.m., indicated "Res (resident) was found on the floor of his roomhe had suffered a laceration above the	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	
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roturo	suffe	red a la	ceration above the					
Ir Iright) and Pragnira						return.	- ' -	
	r (right) eye. Pressure appliedorders to transport res							
to (name of hospital) er	to (name of hospital) er							
(emergency room)"	(eme	ergency	room)"					
A hospital emergency room note, dated 3/25/11, indicated the resident had a facial laceration which required sutures. A nurses' note, dated 3/25/11 indicated: 8:45 p.m., "Resident returned from ERResident transferred to bed ii (two) assist. Res drowsy alert to self only." There was a lack of documentation of an 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur a. New protocol/forms for reporting and investigating bruises /injuries of unknown origin were developed. b. Incident/Accident reports will be placed in designated medical record box on each unit. The incident /accident reports will be collected by medical records during daily Monday through Friday and nursing house supervisor will collect on the week end.	note the r lacer suture A nu indice 8:45 from to be drow Ther	dated 3 esident ration wheres. rses' no eated: p.m., "I ERRed ii (two ysy alert e was a	had a facial hich required te, dated 3/25/11 Resident returned tesident transferred to) assist. Res to self only."			put into place or what systemic changes will be made to ensure that the deficient practice does not recur a. New protocol/forms reporting and investigation bruises /injuries of unknownigin were developed. b. Incident/Accident reports will be placed in designated medical records on each unit. The incident /accident report will be collected by medical records during daily Monday through Friday in nursing house supervisors.	for ng own ord sical and	
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indicated a neurological assessment should have been done. She indicated she would what quality assurance program will be put into place a. The Restorative Nurse/Designee will		assessment of laceration are the resident's was a lack of assessment of 11 p.m., "Resto place and by a o) voice time. Denies was a lack of an assessment of an assessment of the laceration of t	of the resident's ad sutures above is right eye. There if a neurological of the resident. Sident in bed. Alert self. No (indicated ed concerns at this any pain." There if documentation of the resident's accration or of a assessment for the assessment for the terview on 4/19/11. MDS (Minimum bordinator #5 e resident should essessed upon return pital with a head atures. She heurological should have been			Nursing/Designee. c. Director of Nursing /Designee will review incident report /acciden report and initiate investigation. d. After review of investigation by the Dire of Nursing /Designee, th corporate nursing consultant will be inform of findings. The Directo Nursing/Designee will proceed according to Indiana reportable regulations as directed investigation indicates. e. A Directed in-service training on new investigative protocol we provided to nursing staff. A Directed In-Service will be presented on Assessments 4. How the corrective action (s) will be monito to ensure the deficient practice will not recur, in what quality assurance program will be put into place a. The Restorative	ector ne ned r of if ce ill be f. ce ored e.	

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at 1:15 p.m., the First Floor Unit Manager indicated neurological assessments were not done when the resident returned from the hospital until the next day. She indicated the A recap of issues needing to be addressed will be given to the RCC for follow-up and correction as needed. The RCC/Designee will complete the follow-up form and give summary of results to the Director of		D	4/10/11						
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not done when the resident returned from the hospital until the next day. She indicated the needed. The RCC/Designee will complete the follow-up form and give summary of results to the Director of						-	as		
returned from the hospital until the next day. She indicated the complete the follow-up form and give summary of results to the Director of	not done when the resident returned from the hospital until								
the next day. She indicated the and give summary of results to the Director of					_	orm			
the next day. She indicated the results to the Director of									
nurse should have started the Nursing /Designee .The		the next day. She indicated the							
		nurse should	have started the			Nursing /Designee .The			
neurological assessment when Director of Nursing will		neurological	assessment when			_			
the regident returned from the report findings to the Q/a						· · · · · · · · · · · · · · · · · · ·			
committee monthly . This						•	·		
hospital. will be on –going		nospitai.				will be on –going			
A facility policy, titled "Fall		A facility po	licy, titled "Fall						
Prevention", dated 4/3/10,		Prevention".	dated 4/3/10.						
provided by the Director of F 272 D						F 272 D			
		^							
Nurses as current, indicated 1. What corrective action							- I		
"Neurological checks will be (s) will be accomplished for those residents found to									
doneon any resident who has have been affected by the		doneon any resident who has							
had an unwitnessed fall or has deficient		had an unwi	tnessed fall or has						
hit his/her head and		hit his/her he	ead and			A			
documented in the clinical a. A complete skin assessment was completed		documented	in the clinical			•	ated		
record" on Resident # 12. A						-	sieu		
complete skin assessment		10014					ent		

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	F CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		LDING	00 	COMPI 04/20/2	LETED
NAME OF PR	OVIDER OR SUPPLIE	₹		1	DDRESS, CITY, STATE, ZIP CODE	•	
CHICAGO	LAND CHRISTIAI	N VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAG	REGULATORY OR	A LSC IDENTIFYING INFORMATION)		IAG	was completed with no bruises identified. All n issues of bruises /injuriounknown origin will be thoroughly investigated multidisciplinary team comprised of the Direct Nursing/Designee and Resident Care Coordinator/Designee awith an appropriate Resident Care Plan implemented. b. Resident #20 sustal laceration of right eye of 3/25/11 and went to the for further evaluation ar returned within a short period of time. The resi was assessed on the slafter his arrival. He had laceration to right eye requiring sutures which were removed on 3/30/ c. A complete skin assessment was complete skin assessment was completed with no	new ew es of by a or of the and sined on ER nd dent nift a 11.	DAIE
					bruises identified. All n issues of bruises/injurie unknown origin will be	ew	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CO A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 04/20/2011
	ROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				thoroughly investigated multidisciplinary team comprised of the Direct Nursing/Designee and Resident Care Coordinator/Designee awith an appropriate Resident Care Plan implemented. 2. How other resident having the potential to affected by the same deficient practice will be identified and what corrective action (s) will taken a. New investigative protocol for bruises/injured of unknown origin has a developed and implemented this protocol investigate all bruise(s) /injuries of unknown originary team comprised of Director of Nursing/Designee and Resident Care Coordinator/Designee and Resident Care Coordinator/Designee where the tensus that the new investigation protocol is being implemented. Resident be re-assessed using the sident to the comprise of the sident to the sident t	or of the and society gin. In of the will reve swill

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2011
	ROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE
				new protocol and residence plan will be update needed. b. All residents who had hospitalization and an emergency room vibrate been assessed usefurn. 3. What measures will made to ensure that the deficient practice does recur a. New protocol/form reporting and investigate bruises /injuries of unker origin were developed b. Incident/Accident reports will be placed in designated medical rebox on each unit. The incident /accident reports during daily Monday through Fridate nursing house superviewill collect on the weels the Director of	red as have d or sit upon vill be be ne not as for ating nown cord orts edical y and sor k end.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		A. BUILDING	00	(X3) DATE SURVEY COMPLETED 04/20/2011	
		100001	B. WING		04/20/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
CHICAGO	OLAND CHRISTIAN	I VII I AGF	l l	. 117TH AVE 'N POINT, IN46307	
				1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
		,		Nursing/Designee.	
				c. Director of Nursing	1
				/Designee will review	, l
				incident report /accide	nt
				report and initiate	
				investigation.	
				d. After review of	
				investigation by the Di	rector
				of Nursing /Designee,	the
				corporate nursing	
				consultant will be infor	med
				of findings. The Directo	or of
				Nursing/Designee will	
				proceed according to	
				Indiana reportable	
				regulations as directed	l l
				investigation indicates	l l
				e. A Directed in-servi	ice
				training on new	
				investigative protocol v	
				provided to nursing sta	
				f. A Directed In-Serv	rice
				will be presented on	
				Assessments	
				4. How the corrective	_
				action (s) will be monit	
				to ensure the deficient	l l
				practice will not recur,	
				what quality assurance	
				program will be put into	l l
				place	-
				a. The Restorative	
				Nurse/Designee will	
				perform daily audit on	all

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/20/2011			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
				Incident /Accident documentation utilizing Incident/Accident Monitoring Tool. A recap of issues need to be addressed will be given to the RCC for follow-up and correction needed. The RCC/Designee will complete the follow-up and give summary of results to the Director Nursing /Designee .Th Director of Nursing will report findings to the C committee monthly .Th will be on —going	ding e on as o form of ne I		
				F 272 D 1. What corrective a (s) will be accomplished those residents found have been affected by deficient	ed for to		
				 a. A complete skin assessment was comp on Resident # 12. A complete skin assessr was completed with no 	ment		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/20/2011	
	ROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION DATE
				bruises identified. All issues of bruises /inju unknown origin will be thoroughly investigate multidisciplinary team comprised of the Dire Nursing/Designee and Resident Care Coordinator/Designee with an appropriate Resident Care Plan implemented. b. Resident #20 sus laceration of right eye 3/25/11 and went to the for further evaluation returned within a shor period of time .The re was assessed on the after his arrival. He had laceration to right eye requiring sutures which were removed on 3/36	ries of ed by a ctor of d the e and stained on ne ER and t sident shift ad a
				c. A complete skin assessment was com on Resident # 49. A complete skin assess	ment
				was completed with n bruises identified. All issues of bruises/injur unknown origin will be thoroughly investigate	new ries of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2011			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
				multidisciplinary team comprised of the Direct Nursing/Designee and Resident Care Coordinator/Designee with an appropriate Resident Care Plan implemented. 2. How other resider having the potential to affected by the same deficient practice will be identified and what corrective action (s) we taken a. New investigative protocol for bruises/ing of unknown origin has developed and implemented this prowill be used to thorough investigate all bruise(s) /injuries of unknown or A multidisciplinary teat comprised of Director Nursing/Designee and Resident Care Coordinator/Designee be responsible to ensith that the new investigate protocol is being implemented. Resider be re-assessed using new protocol and resident care.	and ants be be ce giuries been btocol ghly s) rigin. m of d the ewill ure tive hts will the		

	F CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		LDING	00 	COMPL 04/20/2	ETED
NAME OF PR	OVIDER OR SUPPLIE	. }	•	1	DDRESS, CITY, STATE, ZIP CODE	•	
CHICAGO	LAND CHRISTIAI	N VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LLSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
1					CROSS-REFERENCED TO THE APPROPRIA	ed as ave or it con II be e e not ing nown ord ts lical and or end.	
					the Director of Nursing/Designee.		

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE C A. BUILDING B. WING	00 	COMPLETED 04/20/2011		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
				c. Director of Nursin /Designee will review incident report /accide report and initiate investigation. d. After review of investigation by the Direct of Nursing /Designee, corporate nursing consultant will be information of findings. The Direct Nursing/Designee will proceed according to Indiana reportable regulations as directed investigation indicates e. A Directed in-servitraining on new investigative protocol provided to nursing staff. A Directed In-Servill be presented on Assessments 4. How the corrective action (s) will be monito ensure the deficient practice will not recur, what quality assurance program will be put integrated as The Restorative Nurse/Designee will perform daily audit on Incident /Accident	irector the rmed tor of d if s. vice will be aff. vice te tored t i.e. e to		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 04/20/2	LETED	
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	04/18/11 at 10:30 a.m., was completed and survive wable and assist her with tracall light was act Restorative Nurse light and the Restorative Restoration Restorat	ar of the C-Hall on 0 a.m. through 10:40 eted with the Restorative ne tour, the Restorative Resident #49 was not d required one person to ansfers. Resident #49's ivated and the e answered the Resident's ident requested to use the Restorative Nurse then		documentation utiliz Incident/Accident Monitoring Tool. A recap of issues ne to be addressed will given to the RCC for follow-up and correct needed. The RCC/Designee will complete the follow- and give summary or results to the Director Nursing /Designee Director of Nursing or report findings to the committee monthly will be on –going	eding be tion as up form f or of The vill e Q/a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING B. WING (X3) DATE SUR COMPLETE 04/20/2011		ETED			
NAME OF	PROVIDER OR SUPPLIEF	<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
				1	117TH AVE N POINT, IN46307		
	HICAGOLAND CHRISTIAN VILLAGE			L	N POINT, IN40307		are.
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	transferred the R	esident onto the toilet.					
	During the trans	fer, with the Restorative					
	Nurse, there wer	e two small purple					
		on the Resident's left					
	1	ring an interview at the					
		rvation, Resident #49					
		l not know how she got					
	1	ing an interview after the					
		d been completed, the					
	Restorative Nurse indicated she had been						
	unaware of the bruises.						
	 Resident #49's re	ecord was reviewed on					
		a.m. The Resident's					
		led, but were not limited					
	1 -	Parkinson's Disease.					
	The Resident's S	lignificant Change					
	Minimum Data S	Set Assessment, dated					
	03/08/11, indica	ted the resident's					
	cognitive status	was moderately impaired					
	with a score of 9	, and the resident					
	1 ^	ve assistance of one					
	person for transf	erring and toileting.					
	The HG 11G	to TTo Joka Am					
	1	vice Update Assessment					
		03/08/11, indicated the					
		rt and long term memory					
	problems.						
	There were no N	Jurses' Notes in the					
		d after 03/15/11. The					
		cked documentation to					
	1	dent's bruising on the left					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	ESURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
ı	nner thigh had be buring an interval.m., the Restoral had informed the the bruises on the thigh. The investigation 04/19/11 at 8:15 resident had three inner left thigh a knee, which mean by 1.5 cm, 1.5 cm, 0.5 cm. This tag was cited facility failed to	LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE A		1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL 04/20/2	ETED
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	I VILLAGE			117TH AVE N POINT, IN46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0280 SS=E	incompetent or oth incapacitated under participate in plant changes in care at the A comprehensive developed within 7 of the comprehensive at the comprehensive of the comprehensive at the comprehensive at the resident's from practicable, the participate staff in by the resident's fami representative; and revised by a team each assessment. Based on observatinterview, the fact residents' care plaupdated, related the falls, mood, and the resident's revisample of 14. (R. #128) Findings include 1. Resident #128 on 4/19/11 at 9:4	care plan must be 'd days after the completion sive assessment; prepared lary team, that includes the n, a registered nurse with ne resident, and other n disciplines as determined leeds, and, to the extent rticipation of the resident, ly or the resident's legal d periodically reviewed and of qualified persons after ation, record review and cility failed to ensure lans were developed and to vision, knee braces, communication, for 4 of lewed for care plans in a lesident's #12, #51, #76, B's record was reviewed 5 a.m. Resident #128's led, but were not limited	F02	280	F 280 E 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient a. Resident 3128 A vis care plan has been initiate. Resident #51 A fall care plan has been update. Resident #76 A care plan for mood has been initiated d. Resident # 12 A care	ated ated	05/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637	A. BUI	LDING	00	COMPLETED 04/20/2011
		155657	B. WIN			04/20/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
CHICAG	OLAND CHRISTIAN	LVIII AGE		1	117TH AVE N POINT, IN46307	
					N FOINT, IN40307	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710	REGULATORT OR	ESC IDENTIFY THIS IN ORIGINATION,		1710	plan addressing	DATE
	A An Annual M	IDS (Minimum Data Set)			communication has bee	an l
		,			e. initiated	711
		completed on 4/1/11.			e. Illitiated	
	· ·	Area Assessment)			2. How other resident	e
	1	red visual function			having the potential to b	
	~~	immary notes indicated			affected by the same	~
	"dx (diagnosis)				deficient practice will be	_
		glassesstaff also is			identified and what	^
		d to position items			corrective action(s) will	he
	directly in front of (resident's name)Will proceed to care plan."				taken	
					a. All Resident care p	lans
	TEN 11 (1	11 1 1			will be reviewed and	
	The resident's rec				updated and or initiated	las
		f a visual function care			needed with focus on	
	plan.				vision, falls, mood and	
					communication.	
	_	ew with the Haven Unit				
		irector, on 4/19/11 at			3. What measures wil	l be
	· ·	ndicated she did not have			put into place or what	
	a care plan for vi	sual function.			systemic changes will b	e
					made to ensure that the	;
	· ·	Recapitulation Orders,			deficient practice does i	not
		ugh 4/30/11, indicated			recur	
	l ` '	knee braces to decrease			a. A Directed In-Servi	ce
	^	& contractures d/t (due			on care plans being	
	to) knee OA (ost	eoarthritis)''			developed and updated	will
					be presented to the	
		vation on 4/19/11 at 9:55			multidiscipline team	
	a.m., resident #12	•			responsible for care pla	ns.
		id not have knee braces			4. How the corrective	
	~	terview at the time of the			action(s) will be monitor	I
	l '	I #4 indicated the			to ensure that the defici	
	1	ars them at night and she			practice will not recur.i.e	e.
	takes them off.				what quality assurance	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	155637		LDING	00	04/20/2		
		100007	B. WIN		ADDRESS CITY STATE ZINCODE	04/20/2		
NAME OF I	PROVIDER OR SUPPLIEF	8		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE				
CHICAG	OLAND CHRISTIAN	N VILLAGE		CROWN POINT, IN46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
IAG	REGULATORY OR	LSC IDENTIFY ING INFORMATION)	+	IAG			DATE	
	The MADIC (Me	diaction Administration			program will be put into place?			
	`	dication Administration			a. All care plans that a	ıra		
	Record) and TAI	Record) did not indicate			scheduled to be completed			
					during the month will be			
		were supposed to be on eate the braces were being			audited by the			
		all the braces were being			MDS/Designee monthly	for		
	put on.				six months .Findings wil			
	The resident's re	oord lacked			reviewed and reported t			
					the Administrator /Desig			
	documentation of a care plan for the knee braces.				who will be responsible			
					report to the Q/A if trend			
	During on interv	iew with the First Floor			identified, audits will be			
	1	n 4/19/11 at 11:07 a.m.,			ongoing until complianc	e is		
		re was not a care plan for			obtained.			
	the knee braces.	re was not a care plan for						
	the knee braces.							
	2. Resident #51'	s record was reviewed on						
		a.m. Resident #51's						
		ed, but were not limited						
	I -	hritis, and congestive						
	heart failure.	, ,						
	Fall Managemen	t Program Notes						
	indicated the res	ident had a fall on						
	1/16/11 and 4/9/	11.						
	A Fall Risk Asse	essment, dated 4/9/11,						
	indicated a score	of 20, which means the						
	resident is a high	risk for falls.						
	The resident's re-	cord lacked						
	documentation o	f a fall care plan.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	
		155637	B. WIN			04/20/2	011
NAME OF F	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE	•	
					117TH AVE		
	OLAND CHRISTIAN			L	N POINT, IN46307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		iew with RN #3, on					
	_	a.m., she indicated there					
	was not a fall car	e plan.					
	During an intervi	iew with the Restorative					
	Nurse, on 4/19/11 at 11:40 a.m., she indicated it doesn't make sense at all why there wasn't a fall care plan. During an interview with the Restorative Nurse, on 4/19/11 at 12:12 p.m., she indicated she had to print the fall care.						
	indicated she had to print the fall care plan off the computer.						
	pian on the comp	Julei.					
	3 Resident #76'	s record was reviewed on					
		a.m. Resident #76's					
		ed, but were not limited					
	_	rheimer's disease, and					
	hypertension.	,					
	_	ange MDS Assessment					
	_	n 2/18/11. The CAA					
		State as a trigger area and					
	was addressed in	the care plan.					
	The manife out	and lastrad					
	The resident's red						
		f a Mood State care plan.					
	An Activity care	plan, dated 2/22/11,					
	-	resident's name)					
		nosis) she rarely to never					
		She does have strong					
		nd visitors daily. They					
		s name) in past interests					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155637	B. WIN			04/20/2011	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEI	₹			117TH AVE		
CHICAG	OLAND CHRISTIAI	N VII I AGE			N POINT, IN46307		
							ars)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
1/10	†			mo	<u> </u>		DATE
	_	, tv, music daily. They					
		mately 3-5 hrs daily.					
		ested that Catholic service					
		prayer wkly with					
	(resident's name)."					
	During an interv	iew with the ADoN					
	(Assistant Direc	tor of Nursing), on					
	4/18/11 at 12:21	p.m., she indicated she					
	did not see a Mood State care plan.						
		1					
	During an interview with the ADoN, on						
	4/18/11 at 1:03 p.m., she indicated Social						
	_	t the Activity care plan					
		they are going to do					
	another one.	they are going to do					
	another one.						
	4 D :1 4 //10						
		's record was reviewed on					
	1 -	o.m. Resident #12's					
	~	led, but were not limited					
	1	ind in right eye, and					
	congestive heart	failure.					
	An Annual MDS	S Assessment was					
	completed on 3/	31/11. The CAA					
	Summary indica	ted Communication					
	triggered and wa	as addressed on the care					
	plan.						
	1						
	The resident's re	cord lacked					
	documentation of						
	communication.	_					
	During an inter-	riony with Social Sorvice					
	During an interv	riew with Social Service					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUI	CTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND FLAN	OF CORRECTION	155637	A. BUILD		00	04/20/2	
			B. WING	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		- 1		117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROWN	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	l	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	there was not a communication. This tag was cited or	1:45 p.m., she indicated are plan for n 2/23/11. The facility failed emic plan of correction to					
F0282 SS=D	facility must be proin accordance with plan of care. Based on obserview, and facility failed physicians' or residents' plan followed related and pressure.	orders and ans of care were ated to medications ulcer prevention s, splint, skin tear s,and fall s for 2 of 14	F02	82	F 282 D 1. What corrective acti (s) will be accomplished those residents found to have been affected by th deficient a. Resident#11 The Go sleeve to left arm was placed on the resident, positioning pillow was placed to ensure proper positioning, hand and ell splint were applied and heels floated. b. Resident #12 The	for ne eri	05/13/2011

STRILLENGY STATE	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE	AND LEAN	or courter nois		- 1				
PREFIX REGILATORY OR LSC IDENTIFYING INFORMATION) PREFIX P				B. WIN	STREET A 6685 E	117TH AVE		
(bruises)geri sleeve to left arm as tolerated"	(X4) ID PREFIX	Findings inc. 1. Residents # Findings inc. 1. Resident reviewed on a.m. Resider included, but to, dementia. A care plan, updated 4/12 "Resident at breakdown in bed" A care plan, updated 4/12 "Risk for bleeding/ecc (bruises)ge	ratement of deficiencies cy Must be perceded by full lsc identifying information) sidents' plans of rsicians' orders in a of 14 residents 11 and #12) lude: #11's record was 4/18/11 at 11:25 nt #11's diagnoses twere not limited and stroke. dated 7/12/10 and e/11, indicated risk for skin and heels while dated 7/15/10 and e/11. indicated whyomosis (sic) eri sleeve to left		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Boniva medication was administered at time of finding 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will taken. a. All residents were assessed to ensure that care plan was being implemented. b. The geri sleeves, positioning devices, spli heel floaters, and other interventions will be place on the residents treatmer record The nurse will be responsible to assure compliance per shift	completion date completion date completion date completion date	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE S COMPLI	
111,2 12,111	or container	155637	A. BUII B. WIN	LDING G		04/20/20	
CHICAG	PROVIDER OR SUPPLIER OLAND CHRISTIAN	I VILLAGE		STREET A 6685 E CROWI	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		ovo.
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	4/12/11, ind (Resident) is decline in Romotion)shout (left) hand A "Restoration Record", dat "Approach resident 7 timprom (passive to L elbow elbow splint at 2 p.m" A care plan, updated 4/12 "risk for familiow in bed positioning Resident #11	(a) (at) risk for OM (Range of e wears a splint to" ve Care Flow ed 4/11, indicated Restorative to see mes a week for ve range of motion) hand splint and . On by 7 a.m. off dated 7/15/10 and 2/11, indicatedMay use body d to aid in			c. All resident physicial orders were reviewed a medication administration recorded reviewed to ensure orders were documented per physicial order and medication administered as ordered. 3. What measures will put into place or what systemic changes will be made to ensure that the deficient practice does recur a. A Directed in-service training on care plans be developed and updated implemented will be presented to nursing state. A Directed in-service training on following physician orders will be presented to nursing state. 4. How the corrective action (s) will be monito to ensure the deficient	and ian	
ı	1/10/11 41 12	p.m., wim			practice will not recur, i.	e.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155637	B. WIN			04/20/2011	
NAME OF E	PROVIDER OR SUPPLIER	<u>u</u>	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	117TH AVE		
CHICAG	OLAND CHRISTIAN	NVILLAGE		CROW	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
1/10		sent, lying in bed		mo	what quality assurance	DATE	
	_	The resident's			program will be put into		
	heels were resting on the mattress and not floated. The				place. a. All Care plans that a	are	
					scheduled to be comple	l l	
					during the month will be		
		not have a splint			audited by MDS/designe		
	on her left a	rm/hand. The			monthly for six months.		
	resident did	not have on geri			Findings will be reviewe Administrator /Designee	· I	
	sleeves nor o	did the resident			who will report to the Q/		
	have a body	pillow in bed for			trends is identified, audi		
	positioning.	•	will be ongoing until				
	1	ed the resident's	compliance reached				
	_				b. RCC/designee will audit physician orders d	ailv	
		ot floated, splint			for change of orders,		
	_	eves were not on,			physician order sheet		
	and there wa	as not a body			monthly, and medication	l l	
	pillow in pla	ice.			administration record a	·	
					treatment records week RCC will report findings	· I	
	2. Resident	#12's record was			monthly to Director of		
	reviewed on	4/18/11 at 1:05			Nursing who will report		
					trends to Q/A monthly.	This	
	•	ent #12's diagnoses			audit will be ongoing.		
	· ·	t were not limited					
	to, osteoporo	osis, dementia, and					
	hypertension	1.					
	•						
	A physician'	s order					
		on, dated 4/11,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637			LDING	NSTRUCTION 00	(X3) DATE COMPL 04/20/2	LETED	
	PROVIDER OR SUPPLIER			STREET A 6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated "1/	/7/08 Boniva (a					
	medication f	for osteoporosis)					
	·	ligrams) 1 tablet po					
	(orally) mon	thly"					
	A MAR (Me	edication					
		on Record), dated					
	· ·	ed the Boniva was					
	to be administered on 3/25/11						
		There was a lack					
		ation on the MAR					
		the medication had					
	been admini	stered.					
	Observation	of the medication					
		'11 at 1:52 p.m.,					
	with the Res	torative Nurse,					
	indicated the	ere were 2 cards of					
	Boniva, whi	ch each contained					
	one tablet, in	the cart for the					
	resident. Th	e Restorative					
		ated the resident					
		ived the Boniva on					
	3/25/11. She	e indicated there					
	should have	only been one card					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
AND FLAN	OF CORRECTION	155637	A. BUIL			04/20/2	
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	with one tab	let in the					
	medication of	eart for this month.					
	The facility failed	vas cited on 02/23/11. d to implement a correction to prevent					
F0323 SS=E	The facility must e environment rema hazards as is poss receives adequate devices to prevent Based on record rev failed to ensure resident without a gamultiple bruising of and not following caprevent further falls falls in a sample of 1 #34) and 1 of 2 resident.	iew and interview, the facility dents received adequate stance to prevent accidents transfer due to transferring a ait belt, which resulted in the the resident after the transfer are plan interventions to for 3 of 12 residents at risk for 14 (Residents #11, #20, and dent who required assistance applemental sample of 2	F0:	323	F 323 F 1. What corrective a (s) will be accomplished for tresidents found to have beer affected by the deficient praca. Resident # 59 Bed pad al was placed per care plan. i. Certified Nursing Assistant # Aide has been re-educated to care plan and informed that resident is at risk for falls. Aid was also re-educated to reviaide assignment card for mo transfer. She has also been instructed to use gait belt to a with transfers. b. Resident#	hose n tice arm 1 o de ew de of assist	05/13/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	ETED
		155637	B. WIN			04/20/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2					
0111040	O. AND OUDIOTIAN			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:				Aide was re-educated that g	ait	
	Č				belt was to be used and two		
	1. During an observation of care on 04/19/11 at 7:18 a.m. with CNA #1 and CNA #2, the following				assist. Aide assignment card		
					care plan updated to reflect		
	was observed:	,			resident current mode of trai	nsfer.	
					c. Resident # 11 OT has		
	CNA #1 and CNA #	² 2 were providing care to			completed evaluation for		
	Resident #60, CNA #1 was changing her gloves when Resident #59 (in the same room as Resident #60) indicated she needed to go to the bathroom and sat up on the side of the bed. CNA #1 then asked the resident to wait, and continued to put on				wheelchair positioning and b	ody	
					pillow was placed to ensure		
					positioning. d. Resident #20		
					Resident has been reassess	ed	
					and body pillow has been		
	the gloves. Resident #59 then stood from the bed,				discontinued. 2. How other		
	the resident's pressure alarm sounded and the				residents having the potentia		
		valk toward the bathroom with			be affected by the same def		
		ly gait. CNA #1 stood by			practice will be identified and		
		and watched the resident walk			what corrective action (s) wi		
		n with a staggared, unsteady			taken a. All residents' care		
		hen stumbled and leaned on the			were reviewed to ensure con mode of transfer was	rect	
	-	pathroom door to support			documented. All Aide assign	mont	
		at time CNA #1 then walked			cards were reviewed to ensu		
	•	to assist the resident to the			mode of transfer on care pla		
	toilet.				was documented on aide ca		
					What measures will be put i		
	CNA #1 then left th	e resident on the toilet in the			place or what systemic chan		
	bathroom to obtain	the resident's supplies for care			will be made to ensure that t		
		m. CNA #1 then provided care			deficient practice does not re		
		left the resident alone in the			a. A Directed in-service trail		
		d CNA#1 then washed her			on care plans being develop	•	
	hands in the sink, lo	ocated outside of the bathroom.			and updated and implement		
	Resident #59 then g	ot up from the toilet herself			will be presented to nursing	staff.	
	and CNA #1 told th	e resident to wait a minute, the			b. New employees have be		
	resident continued t	o walk with a staggered,			issued a gait belt ,employee		
		er own from the bathroom to			have misplaced gait belt hav		
		on the bed, while CNA #1			been given another ,employ		
		t the sink and wash her hands.			who forget to wear gait belt		
	CNA #1 then assiste	ed the resident to lie down in			able to request one from nur		
	the bed.				a supply are now being kept	on	
					nursing unit. c. A Directed		
	During an interview	on 04/19/11 at 7:42 a.m.,			in-service training		
	-				Incident/Accident supervisio	n and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155637 04/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6685 E 117TH AVE CHICAGOLAND CHRISTIAN VILLAGE CROWN POINT, IN46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CNA #1 indicated the resident could ambulate on use of devices will be presented her own and could be left in the bathroom by to nursing staff. 4. How the corrective action (s) will be herself. CNA #1 indicated she had not heard any monitored to ensure the deficient other instructions for the resident's care. practice will not recur, i.e. what quality assurance program will be Resident #59's record was reviewed on 04/19/11 at put into place a. Staff nurses will 7:45 a.m. The resident's diagnoses included, but be responsible throughout their were not limited to, dementia and diabetes shift while making rounds, mellitus. passing medications and when assisting with transfer to monitor The Physician's Recapitulation Orders, dated aides for gait belt compliance to 04/11, indicated the resident was to have a pad ensure transfers are being done alarm on her bed at all times. according to the care plan. This monitoring by staff nurse will be The Fall Management Program Notes indicated: ongoing .The staff nurse will be responsible to document violation 03/11/11- "Resident was observed on floor in of gait belt transfer and polices sitting position next to bed...We will apply bed pad related to following care plan and alarm per MD order." aide card. Staff nurse will forward aide violation documentation to 03/15/11-"...Staff indicates she continues to try to RCC who will meet with aide and self toilet..." discipline as appropriate. RCC will supervise licensed staff for 03/22/11-"...She has STM (short term memory) compliance with transfer policy. deficits and does not remember to call or wait for RCC will provide Director of assist...She remains a fall risk. Will continue Nursing/Designee with monthly current interventions..." report. Director of Nursing /Designee will give monthly report 04/12/11-"...Will continue current interventions..." to Q/a .This will be on-going. The resident's care plan, dated 02/14/11, indicated the resident was unsteady on her feet and was a risk for falls. The interventions indicated, "...She is able to ambulate with hand held assist...03/11/11 Bed pad alarm..." The undated CNA Care Record, indicated the resident was a "Huge" fall risk and required assistance for safe transfers, walking, and toilet use.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155637	B. WIN			04/20/2	011
		1	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			117TH AVE		
CHICAG	OLAND CHRISTIAI	N VII I AGE			N POINT, IN46307		
			_		14 1 On 11, 114-0007		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	 	TAG			DATE
		's record was reviewed on	F0	323	F 323 F 1. What corrective a (s) will be accomplished for the		05/13/2011
	4/19/11 at 9:15 a	n.m. Resident #34's			residents found to have beer		
	diagnoses includ	led, but were not limited			affected by the deficient prac		
	to, dementia, ost	eoarthritis, and muscle			a. Resident # 59 Bed pad al		
	weakness.	•			was placed per care plan. i.		
					Certified Nursing Assistant #		
	A Quarterly MD	S assessment dated			Aide has been re-educated t	0	
	A Quarterly MDS assessment, dated				care plan and informed that		
	2/11/11, indicated Resident #34's cognition was severely impaired. The				resident is at risk for falls. Aid		
					was also re-educated to revi		
	MDS assessment indicated the resident				aide assignment card for mo transfer. She has also been	ue oi	
	required extensive two staff assistance for				instructed to use gait belt to	assist	
	transfers.				with transfers. b. Resident#		
					Aide was re-educated that g	ait	
	A Fall care plan	dated 11/24/11 and			belt was to be used and two		
	_	indicated the resident was			assist. Aide assignment card	l ,	
	a one staff assist				care plan updated to reflect		
	a one starr assist	for transfers.			resident current mode of trar	isfer.	
					c. Resident # 11 OT has		
		ties of Daily Living) care			completed evaluation for wheelchair positioning and b	ody	
	plan, dated 11/12	2/11 and revised 2/22/11,			pillow was placed to ensure		
	indicated Transf	er with two staff and use			positioning. d. Resident #20	•	
	of gait belt.				Resident has been reassess		
					and body pillow has been		
	An undated CNA	A Care Record, indicated			discontinued. 2. How other		
		aired 2 staff assistance			residents having the potentia		
	1				be affected by the same defi		
	with the use of a	gait belt for transfer.			practice will be identified and what corrective action (s) wil		
		1 . 1 2 /2 / / / =			taken a. All residents' care		
	1	dated 3/31/11 at 7:00			were reviewed to ensure cor	-	
	p.m., indicated "	CNA assisting resident c/			mode of transfer was		
	(with) HS (hour	of sleep) care clothing			documented. All Aide assign		
	removed. Large	area of bruising noted to			cards were reviewed to ensu		
	1	e/red in color 10.2 cm x			mode of transfer on care pla		
		size. purple /red color to R			was documented on aide car		
	1	em x 1.8 cm. 4 separate			What measures will be put in place or what systemic chan		
		_			will be made to ensure that t	-	
	i large purple brui	ises to R side below axilla	1		will be made to chouse that t		l

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMP				
		155637	A. BUI B. WIN			04/20/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹	_!	1	DDRESS, CITY, STATE, ZIP CODE		
CHICAC	OLAND CHRISTIAI	NIVIII ACE		1	117TH AVE N POINT, IN46307		
				<u> </u>	N POINT, IN40307		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
PREFIX TAG	(armpit), on rib of proximal-dark proximal-dark proximal-dark proximal-dark proximal-dark proximal-dark proximal-dark proximal-dark proximal-dark proximal p	cage area 1. urple 4.5 cm x 15 cm, 2. dk (dark) purple, 3. 1.5 distal dk purple 2 cm x at is cognitively impaired for information regarding y have incurred. Denies report, dated 3/31/11 and the resident was one assist by a CNA and a use a gait belt. riew on 4/19/11 at 10:14 Director of Nursing) investigation revealed insferred the resident by hout the use of a gait belt.		PREFIX TAG	deficient practice does not rea. A Directed in-service train on care plans being develope and updated and implemente will be presented to nursing sb. New employees have be issued a gait belt ,employees have misplaced gait belt have misplaced gait belt have been given another ,employee who forget to wear gait belt vable to request one from nursing unit. c. A Directed in-service training Incident/Accident supervision use of devices will be present to nursing staff. 4. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e. who quality assurance program we put into place a. Staff nurses be responsible throughout the shift while making rounds, passing medications and who assisting with transfer to more	ecur ing ed ed staff. en s who e ess vill be se as on and ited cient iill be s will eir en nitor	COMPLETION DATE
	1 ^	by the DoN on 4/19/11 at			aides for gait belt compliance ensure transfers are being do		
		cated "gait belts are sidents requiring			according to the care plan. The monitoring by staff nurse will	⊺his	
		ransfers unless the			ongoing .The staff nurse will		
		n assessed to need a			responsible to document viol	ation	
	mechanical lift of	or is a stand by assist			of gait belt transfer and police related to following care plan		
	resident. Nursin	g staff are required to			aide card. Staff nurse will for		
	have a gait belt a	as part of their uniform			aide violation documentation	to	
	attire"				RCC who will meet with aide		
					discipline as appropriate. RC will supervise licensed staff f		
					compliance with transfer poli		
					RCC will provide Director of		
					Nursing/Designee with montl	nly	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 04/20/2	LETED
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CO 117TH AVE N POINT, IN46307	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	3. Resident reviewed on a.m. Reside included, but to, dementia. A Nurses' Not 10:30 a.m., if found on the (hour) by this alert and statistic out of the A care plan, updated 4/12 "risk for fapillow in bed positioning	#11's record was 4/18/11 at 11:25 nt #11's diagnoses t were not limited , stroke, and stroke. ote, dated 4/3/11 at ndicated "Res was floor this hr is writer. res was ted that she had he chair" dated 7/15/10 and 2/11, indicated hllsMay use body d to aid in		(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A	HOULD BE APPROPRIATE URSING NONthly report	
	positioning	or w/c (wheelchair) ." agement Program				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Notes", date	d 4/3/11, indicated					
	"Res was he	ard calling for					
	nurse. When	nurse entered					
	room he obs	erved resident on					
	floor in lying	g positionOT to					
	eval et (and)	tx (treat) res for					
	w/c position	ing"					
	4/18/11 at 12 LPN #6 preson her back. not have a befor positioning	ed there was not a					
	documentati	's record lacked on of an evaluation by Occupational wheelchair					
	During an in at 12:32 p.m	terview on 4/18/11 ., the					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	N VILLAGE			N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Rehabilitation	on Manager					
	indicated the	e resident had not					
	received any	Occupational					
	Therapy in M	March or April.					
	at 1:13 p.m Manager incorreceived an occupational evaluate and resident had the hospital order they had	I Therapy to I treat but the been sent out to on 4/8/11 and the ad was no longer d they needed a					
	reviewed on a.m. Reside included, bu to, psychotic	#20's record was 4/19/11 at 11:20 nt #20's diagnoses t were not limited e mood disorder, nd depression.					
	A Significan	t change MDS,					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/20/2	LETED
	PROVIDER OR SUPPLIER		<u></u>	STREET A 6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
	dated 4/14/1	1, indicated the					
	resident was	moderately					
	impaired wit	th decision making					
	and cognitio	n. The resident					
	required lim	ited assistance of					
	one staff me	mber for bed					
	mobility.						
	A care plan, dated 1/10/11 and						
	•	4/11, indicated					
	"has a hist	ory of fallsbody					
	pillow in bed	d for positioning"					
	A Nurses' No	ote, dated 4/14/11					
	at 7:45 p.m.,						
	_	ed fall: CNA called					
	nurse to room	m. Resident sitting					
		esident request (sic)					
		lp when needed &					
		t to get help."					
		• •					
	A "Fall Man	agement Program					
	Notes", date	· ·					
	•	es was observed on					
	floor in roon	nRes stated he					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/20/2	ETED
	PROVIDER OR SUPPLIER		p. wnw	STREET A 6685 E	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
		t (and) out of the ll try a body pillow h) him for					
	positioning.'	<i>'</i>					
	lying in bed pillow in pla 10:40 a.m., 1	was observed without a body ce on 4/18/11 at 11:17 a.m., and 06 a.m., and 11:30					
	lying in bed pillow in pla 11:35 a.m., v present. CN resident's bo in place. Sh	without a body ce on 4/19/11 at with CNA #8 A #8 indicated the dy pillow was not e indicated the was on the floor in s room.					
	lying in bed) was observed on 4/19/11 at there was a body					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CO A. BUILDING B. WING	BUILDING 00 WING		(X3) DATE SURVEY COMPLETED 04/20/2011	
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CO 117TH AVE N POINT, IN46307	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
		at the foot of the					
	bed.						
	above date a Floor Unit N the body pill right place. A facility po Prevention", provided by Nurses as cu is the policy resident with assessment a prevent falls based on res	deterview at the and time, the First Manager indicated low was not in the licy, titled "Fall dated 4/3/10, the Director of arrent, indicated "Itto provide each appropriate and interventions toInterventions ident assessment ed on the resident's					
	The facility faile	vas cited on 02/23/11. d to implement a correction to prevent					

l		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLI A. BUILDING B. WING	00	COMP 04/20/	LETED
	PROVIDER OR SUPPLIER		668	EET ADDRESS, CITY, STATE, ZIP 5 E 117TH AVE OWN POINT, IN46307	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
	3.1-45(a)(2) Surveyor: Sanders, 1					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	A. BUILDING	E CONSTRUCTION (X3) DATE SU 00 COMPLET 04/20/201		ETED
	PROVIDER OR SUPPLIER		668	EET ADDRESS, CITY, STATE, ZIP CODE 5 E 117TH AVE OWN POINT, IN46307	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CO	
F0441 SS=E	The facility must e Infection Control P a safe, sanitary an and to help prevent transmission of distribution o	stablish an Infection Control nich it - controls, and prevents cility; procedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted	TAG		RIALE	DATE
	infection. Based on observa	as to prevent the spread of ation, record review, and	F0441	F 441 F		05/13/2011
	infection control to prevent the spi	measures were followed read of infection related and a clean linen cart		What corrective a (s) will be accomplish those residents found	ed for	

li ´			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155637	B. WIN	IG		04/20/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	-
0111040	O. AND OUDIOTIAN				117TH AVE	
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	_ ^	plies stored inside for 2			have been affected by t	ne
		lower level, which had			deficient.	
	_	ffect 49 of 78 residents,			a. Linen cart had artic	
		e Lower Level Unit. (B			other then linen remove	a.
	and C Halls, Res	ident #60 and CNA #1)			b. Resident #60 was	
					assessed and at this tim	ie
	Findings include	:			has no infection	
					c. Certified Nursing Assistant #1 was	
		nen cart was observed on				
	4/18/11 at 10:05 a.m. The linen cart was observed to contain four tubes of				re-educated regarding	.
					handwashing policy and procedure and did a ret	
	1 ^	intment, four toenail			demonstration.	uiii
	clippers, one hair	rbrush, and four boxes of			demonstration.	
	gloves.					
					2. How other residents	
		iew on 4/18/11 at 10:05			having the potential to b	
	· ·	Nurse indicated she did			affected by the same	
	1	e above items were			deficient practice will be	,
	stored in the clea	n linen cart.			identified and what	
					corrective action (s) will	be
	"	iew on 4/18/11 at 10:08			taken	
		cated it was her job to			a. All residents on B a	nd
		ems were not stored in the			C hall on lower level ha	ve
	clean linen cart.				been assessed and hav	re
					not developed infections	s at
		servation of care on			this time.	
		a.m. with CNA #1 and				
	CNA #2, the foll	owing was observed:			3. What measures wi	ll be
					put into place or what	
		A #2 were providing care			systemic changes will b	e
	Í	CNA #1 had gloves on			made to ensure that the	:
	and had provided	l incontinence care to the			deficient practice does r	not
	resident. During	the observation of the			recur	
	care, CNA #1 ha	d indicated the resident			a. Infection Control	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE S) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155637	B. WIN			04/20/2	011	
		l .	D. WIN		DDRESS, CITY, STATE, ZIP CODE	l .		
NAME OF	PROVIDER OR SUPPLIEF	8			117TH AVE			
CHICAG	OLAND CHRISTIAN	N VILLAGE		1	N POINT, IN46307			
				L .			(V.5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE	
1710	†	nent. CNA #1, then	+	1110	In-Service will be preser	atod	BillE	
	1	· ·			to all facility staff with	iteu		
	1	continent brief and began			emphasis on hand wash	nina		
	1	A #2 in dressing the			and proper handling of I	-		
		washing hands and						
	1	During an interview at			and linen carts, Facility will be required to give a			
	1	bservation, CNA #1			return demonstration of	1		
	1 **	ng to do the resident's				,		
	1	ed she should have			hand washing technique			
		ls and put on new gloves.			 b. Quarterly hand was in services will be held f 	_		
CNA #1 then took off the soiled gloves and washed her hands.					OI			
				nursing staff with return				
					demonstration.	-1-		
	CNA #1 then assisted the other resident				c. Nursing staff, on ea			
	in the room (Res	sident #59) and helped the			shift, will be responsible			
	other resident lay	y down in bed and		monitor clean linen carts,				
	covered the resid	lent up. CNA #1 then			on their units.			
	returned to Resid	dent #60 and continued to			4			
	help CNA #2 dre	ess the resident and	4. How the corrective					
	1 -	lent into the chair. CNA		action (s) will be monitored				
	#1 did not wash	her hands prior to			to ensure the deficient			
		for Resident #60. CNA			practice will not recur, i.	e.		
	1	esident #60's bed. During			what quality assurance			
	an interview at the	•			program will be put into			
		A #1 indicated she had			place			
	1	nands between residents.						
	1	oably forgetting stuff, I'm			a. Infection control lo	-		
	1				will be summarized and	an		
		CNA #1 had gloves on, at #60's room without			infection report will be	_		
	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '				Presented by the Direct			
	1 -	ds. The CNA had the			Nursing/designee to the			
		linen in plastic bags and			monthly QA committee.			
	1 ^	ne appropriate bins in the			The Medical Director wi	ll be		
	I -	d her gloves and entered			responsible to sign the			
	1	s room across the hall and			monthly reports. This w	rill		
	washed her hand	s in the bathroom.			be ongoing.			

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637	A. BUILDING	00	COMPLETED 04/20/2011
		155657	B. WING		04/20/2011
NAME OF F	PROVIDER OR SUPPLIER		1	ADDRESS, CITY, STATE, ZIP CODE	
CHICAG	OLAND CHRISTIAN	JVILLAGE	I	E 117TH AVE /N POINT, IN46307	
				1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
			İ	b. The unit RCC/design	nee
		ed, "Handwashing", dated		will responsible to moni	f
		m Nurse Consultant as current,		hand washing and will b	I
		priatehandwashing must be e following conditions:5.		responsible to have each	
	-	ged contact with a patient; 6.		staff member complete	
		linen, etc.;8. After handling		quarterly hand washing	test
		ntaminated with a patient's		and return demonstration	on.
	blood, body fluids	9. After removing gloves"		The Director of	
	3.1-18(1)			Nursing/designee will	
	3.1-19(g)(1)			present the quarterly ha	
	O , ()			washing data to the QA	
				committee quarterly. The	nis
				will be ongoing	
				c. The unit	
				RCC/designee will be	
				responsible to monitor I	inen
				carts weekly .The finding	I
				will be reported to the	
				Director of Nursing. Th	e l
				Director of Nursing will	
				present findings quarter	ly to
				the QA committee. This	-
				be ongoing.	
				F 441 F	
				1. What corrective act	ion
				(s) will be accomplished	
				1 (3) This se decempnesses	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 04/20/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				117TH AVE	
	OLAND CHRISTIAN			N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				those residents found to have been affected by deficient. a. Linen cart had articulate other then linen remove be Resident #60 was assessed and at this time has no infection c. Certified Nursing Assistant #1 was re-educated regarding handwashing policy and procedure and did a redemonstration. 2. How other resident having the potential to affected by the same deficient practice will be identified and what corrective action (s) wittaken a. All residents on Be C hall on lower level has been assessed and had not developed infection this time. 3. What measures we put into place or what systemic changes will made to ensure that the deficient practice does recur	the cles ed. me d turn ts be e ll be and ave ve ns at vill be be e e

001198

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AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	A. BUII	A. BUILDING 00		COMPLETED 04/20/2011	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE				
CHICAGOLAND CHRISTIAN VILLAGE			CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE C	(X5) COMPLETION DATE	
					a. Infection Control In-Service will be prese to all facility staff with emphasis on hand was and proper handling of and linen carts, Facility will be required to give return demonstration of hand washing technique b. Quarterly hand was in services will be held nursing staff with return demonstration. c. Nursing staff, on eashift, will be responsible monitor clean linen cart on their units. 4. How the corrective action (s) will be monitor to ensure the deficient practice will not recur, i what quality assurance program will be put into place a. Infection control to will be summarized and infection report will be Presented by the Direct Nursing/designee to the monthly QA committee. The Medical Director w responsible to sign the monthly reports. This v	hing linen staff a se. shing for a che to es, ored lee. lee. lee lill be lill be	

001198

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CONSTRUCTION A. BUILDING O			(X3) DATE SURVEY COMPLETED 04/20/2011		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			B. WING 04/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	HOULD BE COMPLETION		
					be ongoing. b. The unit RCC/desig will responsible to monit hand washing and will be responsible to have each staff member complete quarterly hand washing and return demonstration. The Director of Nursing/designee will present the quarterly had washing data to the QA committee quarterly. The will be ongoing. c. The unit RCC/designee will be responsible to monitor licants weekly. The finding will be reported to the Director of Nursing. The Director of Nursing will present findings quarter the QA committee. This be ongoing.	or e h test n. nd is nen gs		
R0000			R0	000				

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		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/20/2011		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)				.IE	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC12 Facility ID:

001198

If continuation sheet

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